Report to

House of Representatives Appropriations Subcommittee on Health and Human Services,

Senate Appropriations Committee on Health and Human Services,

Fiscal Research Division, and

Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services

ON

ANALYSIS OF SERVICE GAPS IN THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICE SYSTEM

SESSION LAW 2008-107, HOUSE BILL 2436

DRAFT – February 8, 2010 – DRAFT

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

This report is provided in response to Session Law 2008-107 (HB 2436) Section 10.15(f), which reads:

> *The Department shall perform a services gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System. The Department of Health and Human Services shall involve LMEs in performing the gap analysis."*

The report summarizes the service gaps and priorities identified by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services the Local Management Entities (LMEs), and other local and state partners, including Consumer and Family Advisory Committees, NC Institute of Medicine task forces, and MH/DD/SA advocacy groups. The service gaps and needs that these stakeholders identified fall into six main themes:

- **Long Term Supports for Independence and Recovery**, including emergency services, affordable medications, primary healthcare, and other supports for community living
- **Quality and Accountability**, including the use of evidence-based practices
- **Workforce Development**, including provider trainings in core and specialty areas and residency rotations in substance abuse and developmental disabilities
- **Expansion of Services**, particularly for rural areas, dual disability services, and community inpatient services
- **Services for Vulnerable Populations**, including deaf persons, persons undergoing transitions, high-risk youth and persons with chronic illnesses and justice system involvement
- **Leadership and System Management**, including State and local disability-specific specialists, interagency collaboration and cooperation, and use of effective funding policies (e.g. consumer-directed budgets)

The Department has taken into consideration these needs, recent efforts in these areas, 2009 legislative requirements, the current economic situation, and the State's long-term goals for the MH/DD/SA service system in developing its immediate priorities. The priorities of the Department for the MH/DD/SA service system are to:

- improve the quality and stability of the service system,
- maximize use of existing resources, and
- protect critical core services, including crisis services.

Two new initiatives are currently underway to address these goals, while continuing to move the system forward in the areas identified in this report by the LMEs and other stakeholders.

- Expansion of Medicaid Waivers 1915 (b) and (c)
- Critical Access Behavioral Health Agencies

These initiatives, along with other initiatives to address legislative requirements and the needs identified by stakeholders, are described in the last section of the report.

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Introduction

This report is provided in response to Session Law 2008-107 (HB 2436) Section 10.15(f), which reads:

> *The Department shall perform a services gap analysis of the Mental Health, Developmental Disabilities, and Substance Abuse Services System. The Department of Health and Human Services shall involve LMEs in performing the gap analysis. The Department shall not contract with an independent entity to perform the gap analysis. The Department shall report the results of its analysis to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than January 1, 2010.*

The following pages and appendices provide a summary of the service gaps and priorities identified by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the people it serves, and its local and state partners.

MH/DD/SAS System Overview

The public system of mental health, developmental disabilities, and substance abuse services (MH/DD/SAS) in North Carolina consists of five main components: (1) the individuals who receive services ("consumers"), their family members and other advocates; (2) for-profit and not-for-profit agencies that provide community-based services; (3) local management entities (LMEs) that manage and oversee services; (4) fourteen state facilities for inpatient care, and (5) the NC Department of Health and Human Services (DHHS).

Consumers and family members influence the shape and direction of the service system through direct feedback to service providers and oversight agencies, response to surveys, complaints and grievances, and advocacy efforts. In addition, the State and each LME has a Consumer and Family Advisory Committee (CFAC) comprised of representatives of each of the three disability groups. Among the responsibilities of the CFACs is identification of service gaps and community needs from the perspective of those who rely on the system for services.

Private provider agencies deliver services through contracts or memoranda of agreement with LMEs and through enrollment as Medicaid providers. Providers are responsible for development and implementation of person-centered service plans for consumers, acting as first-responder when their consumers are in a crisis, delivery and documentation of services, planning for service transitions, and submission of necessary consumer information to LMEs and DHHS.

The 100 counties of North Carolina are clustered in 24 multiple- or single-county LMEs, which manage the delivery of services. The LMEs are local government agencies that are responsible for authorizing, coordinating, facilitating and monitoring services and supports in their catchment areas. LME responsibilities include authorizing the use of State appropriations and federal block grant funds for MH/DD/SA services, screening and offering individuals around-the-clock access to services and supports, endorsing and contracting with providers to deliver services, overseeing the provider community, coordinating services across agencies, supporting consumer and family involvement in local decisions, and responding to individuals' complaints and grievances.

Four divisions within DHHS have responsibilities for managing the MH/DD/SA service system. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS or the Division) is responsible for setting and enforcing policies and regulations, allocating federal and state funds, and overall management of the community service system.

The Division of State Operated Healthcare Facilities (DSOHF) manages three psychiatric hospitals, three alcohol and drug treatment centers, three developmental centers, three neuro-medical centers, and two child residential treatment centers. The Division of Health Service Regulation (DHSR) is responsible for licensing state and community facilities and assuring their compliance with state regulations. The Division of Medical Assistance (DMA) is responsible for providing and overseeing the use of Medicaid funds for MH/DD/SA services.

Context of the Study

Transformation of the public MH/DD/SA service system began in the fall of 2001 after the North Carolina General Assembly enacted legislation for the reform of the system. The mission, vision and guiding principles of the MH/DD/SA services system were laid out in the original State Plan 2001 and refined in 2006. As shown below, these statements capture the essential values for the system.

Vision

North Carolina residents with mental health, developmental disabilities and substance abuse service needs will have prompt access to evidence-based, culturally competent services in their communities to support them in achieving their goals in life.

Mission

North Carolina will provide people with, or at risk of, mental illness, developmental disabilities and substance abuse problems and their families the necessary prevention intervention, treatment services and supports they need to live successfully in communities of their choice.

Guiding Principles

- *Participant driven.*
- *Community based.*
- *Prevention focused.*
- *Recovery outcome oriented.*
- *Reflect best treatment/support practices.*
- *Cost effective.*

The primary goal of the public service system is to provide individuals with mental illnesses, addictive disorders and developmental disabilities opportunities to live in communities of their choice, while reserving state-operated institutions for those with the most severe needs. Such opportunities require a high-quality community system with an adequate array of effective services and supports, including crisis services. "Effective" means that the services and supports produce the *desired outcomes* for individuals using *person-centered planning* and *best practices* within *available resources*. This goal can only be achieved through *continuous improvement* of the system based on established *performance standards* and *measuring progress* on a regular basis.

The public MH/DD/SAS system has undergone a number of changes in the past decade as Mental Health Reform has been implemented. Although most of the major changes were intentionally enacted, some unintended consequences of the reform efforts caused or necessitated additional mid-stream corrections. Major changes have included:

- **Divestiture of area program services.** Local government agencies have transformed from area authorities that delivered services to management entities that develop and oversee a community of private agencies that deliver services. This change in structure of the system has provided better management of the service system, while requiring a reduction of LME staff and a major shift in the duties and needed skills of remaining staff.
- **Merger of local management entities.** The 41 area authorities of SFY 2000 had merged into 24 LMEs by SFY 2009, with additional realignment of counties occurring across LMEs. This consolidation has resulted in more efficient use of administrative funds, and challenged LMEs by requiring further staff reductions and better coordination of responsibilities across larger geographical areas.
- **Introduction of "enhanced benefit" services.** These twenty-one (21) new services, designed to support the delivery of best-practices and desired outcomes for individuals, were implemented in SFY 2006. Rapid implementation of these services, as required by the Centers for Medicaid and Medicare Services (CMS) after long delays in approval, brought challenges of over-capacity in some services and under-capacity in others. As more private provider agencies came into the system, LMEs have seen a growth in their endorsement, training, and oversight responsibilities and a greater need for coordination of care across agencies.
- **Provision of single-stream funding.** Half of the LMEs qualified for single-stream funding in SFY 2009, which allows greater flexibility in the use of state funds, but has reduced the quality and completeness of data available to the DHHS for planning and oversight.
- **Implementation of multiple CAP-MR/DD waivers and planning for additional Medicaid waivers.** Medicaid waivers are designed to direct funds effectively, make services accessible for more people, and improve the quality and outcomes of those services. Managing waivers requires a specific set of skills and functions that alter the culture of the system and direction of the workforce at all levels.
- **Competition among stakeholder groups within the MH/DD/SAS system to influence the plans for redesign of the service system structure.** Any restructuring of a system results in winners and losers among major stakeholders. As long as that system remains in flux, those with a "stake" have incentives to shift the developing system to their advantage. Stakeholders' efforts to influence policy have helped to refine the course of reform, while creating multiple changes in direction and confusing expectations among people who depend upon the service system.
- **Current worldwide economic recession.** This serious situation has resulted in greater need for services coupled with loss of funding for a perennially underfunded system, despite legislative efforts to support MH/DD/SAS initiatives. While this has created opportunities to streamline the system in some needed areas, it has also resulted in a reduction of service capacity and oversight capacity at both the state and local levels during a time of increased need.
- **Legislated reductions in community support services, child residential services, and personal care services, along with a consolidation of case management functions across DHHS agencies**. These legislated changes have created opportunities to control spending and direct services to the people most in need in a more cost-effective way. At

the same time, the pace at which plans must be laid will undoubtedly require further refinements and create unintended consequences over the course of the coming year.

All of these changes have had positive impacts on the shape of the service system, while creating challenges that have kept the system from fully stabilizing.

Approach and Methodology

A gap analysis is best conducted in a system with a clear vision and set of goals, stable service agencies, several years of consistent data for analysis, and adequate staff resources. Despite the past shifts and impending changes to the MH/DD/SAS system mentioned above, this report provides a reasonable picture of current needs in relation to goals for the service system.

Creation of a stable, effective community service system is a prerequisite for providing people with MH/DD/SA service needs opportunities for community living and for reducing reliance on state institutions. Therefore, this analysis focuses on the gaps in community services. The gaps and priorities described in the body of this report are those identified by CFACs, stakeholder groups, LMEs, DHHS and the NC Institute of Medicine.

Sources of Information

Four primary sources of information provide the content for the gap analysis – the annual LME Needs Assessments, the annual CFAC Gap Analyses, special Legislative studies and initiatives, and DHHS service claims data.

- **LME Needs Assessments:** Each LME is required, as part of the *DHHS-LME Performance Contract*, to complete a comprehensive review of their local service system annually and to identify needs and set priorities based on the findings of that review. For their SFY 2009 Needs Assessments, some LMEs used the Division's recommended format and guidelines and others used a locally-developed approach. LMEs conducted assessments using (1) qualitative information gathered from stakeholders, community members and sister agencies and (2) quantitative information gleaned from their administrative databases and Division reports.
- **Local CFAC Gap Analyses:** Each local CFAC produces an annual report to the State CFAC that identifies the most important service gaps and community needs from the perspective of individuals receiving services and their family members. These reports are combined into a statewide report that is presented to DHHS and the Joint Legislative Oversight Committee on MH/DD/SAS. This report includes CFAC recommendations from SFY 2008-09.
- **Legislated NC Institute of Medicine Studies:** Additional resources for this report have been garnered from two special studies by the NC Institute of Medicine (NCIOM) that were funded by the NC General Assembly. The first study examined the status and gaps in the substance abuse service system. The second study focused on the needs of people with developmental disabilities in transition, specifically (1) transitions for adolescents leaving high school; (2) transitions for persons who live with aging parents; and (3) transitions for people who move from developmental centers to other settings. These studies were completed and presented to the General Assembly in 2009. The NCIOM is currently studying the support needs of military personnel, veterans and their families, including their need for MH/DD/SA services.

- **DHHS Service Claims data:** The Division of MH/DD/SAS and Division of Medical Assistance (DMA) regularly use reimbursement information on services provided using Medicaid, federal block grant, and state funds to track the capacity of the services system. This report provides a summary of services provided in SFY 2008-09 as a means of describing the current status of the service system. Although most services are funded through claims-based unit-cost reimbursement to providers, not all services are captured in the claims data, as some specialty programs are funded through grants to providers.[1]

All of the sources of information used for this report were completed before the current economic situation required drastic cuts in MH/DD/SA services for SFY 2009-10. Implementation of plans to eliminate community support services, reduce residential treatment services for children, consolidate case management, and restrict personal care services are underway, as this report is being finalized. While these changes do not diminish the importance of the gaps identified by DHHS and its partners, it is likely that additional needs will become apparent as these changes are implemented.

Organization of the Report

This report focuses on identifying areas of strength and concern through scrutiny of these resources in light of current goals for the service system. The next section provides a brief description of the current service system. This is followed by a summary of the gaps, needs and priorities identified by stakeholders in each LME and CFAC. Separate sections provide a summary of recommendations from the NCIOM studies and from specific disability stakeholder groups. The final section summarizes findings and priorities of the Department.

The Current Service System

Mental Health Services

Mental illness encompasses a broad array of health conditions with varying impacts on an individual's life. Mental disorders are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. These alterations contribute to a host of problems—individual distress, impaired functioning, and heightened risk of death, pain, disability, or loss of freedom.

Mental illnesses exact a staggering toll on individuals, as well as on their families, communities and our nation as a whole. Impaired functioning from mental illness often results in social isolation, loss of productivity, homelessness, incarceration, chronic medical conditions and premature death.

Appropriate treatment can alleviate, if not cure, the symptoms and associated disability of mental illness. With proper treatment, the majority of people with mental illness can return to productive and engaging lives.

North Carolina has designed its public mental health system to serve those persons with the greatest functional impairment and thus the highest need for ongoing specialty care. The state

[1] While these data offer the most complete picture of services across the state, the use of single-stream funding by twelve LMEs and the use of grant-based funding for some services by other LMEs, results in some missing information in the claims data, notably data on substance abuse services.

also targets those residents with limited access to privately-funded services. High need groups include adults with severe and persistent mental illness, elders with mental illness, and individuals with mental illness who are homeless or involved with the criminal justice system.

In addition, children and youth with serious emotional disturbances often have complex service needs, due to chronic health conditions (e.g. fragile diabetes), need for special education, and/or involvement with social services or the juvenile justice system. The Division embraces System of Care as an organizing framework for the delivery of children's services in North Carolina. This framework relies on involving youth and their families as partners in planning and coordinating services and working collaboratively across child-serving agencies to meet the individualized needs of the child and family. Working together as partners helps to minimize the impact of problems and improve youth's recovery of control over their lives.

The tables below provide summaries of mental health services provided in North Carolina in SFY 2009 through state and federal claims-based funds.[2]

Table 1: Adult Mental Health Services, SFY 2008-09

Adult MH Service[3]	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Case Support	240	4,309	$2,803,443	$76,171	$2,879,614
Community Support	1,259	32,106	$11,208,583	$134,804,407	$146,012,990
NOTE: Community support will be eliminated June 30, 2010. The Division estimates that roughly two-thirds of the persons who received Community Support in SFY 2009 will need case management or another replacement service.					
Community Support Team*	429	6,953	$5,248,563	$101,193,374	$106,441,937
Psychosocial Rehabilitation*	134	3,235	$2,185,241	$16,177,910	$18,363,151
ACTT*	106	3,557	$6,889,864	$30,611,844	$37,501,708
Outpatient Therapy	3,830	83,977	$7,876,176	$26,440,022	$34,316,198
Medication Management	916	59,946	$3,450,269	$5,220,110	$8,670,379
Supported Employment	68	618	$1,146,614	$0	$1,146,614
Inpatient Hospitalization*	189	11,093	$18,607,788	$41,068,628	$59,676,416
Inpatient Physician Services*	270	15,457	$388,381	$5,071,793	$5,460,174
Residential Services	393	517	$16,520	$9,416,012	$9,432,532
Residential Supports	291	1,494	$14,929,837	$0	$14,929,837

[2] Service claims data in the tables here include unit-cost reimbursement services paid through federal block grant funds, Medicaid funds and state appropriations as of November 30, 2009. The data exclude Medicare-funded services, grant-based (non-unit based) services, and low volume services. Services provided through county funds and private funds are included only if the LME has elected to report them in the Integrated Payment and Reporting System..

[3] Services with an asterisk (*) include consumers with other disability diagnoses listed on the claim.

Table 2: Child & Adolescent Mental Health Services, SFY 2008-09

Child MH Service[3]	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Case Support	57	2,356	$93,854	$126,838	$220,692
Community Support	1,146	42,731	$4,224,409	$276,089,189	$280,313,598
NOTE: Community support will be eliminated June 30, 2010. The Division estimates that roughly two-thirds of the persons who received Community Support in SFY 2009 will need case management or another replacement service.					
Day Treatment*	165	3,720	$1,741,500	$43,519,134	$45,260,634
Inpatient Hospitalization*	54	3,356	$752,302	$25,699,154	$26,451,456
Inpatient Physician Services*	160	3,764	$7,066	$2,783,559	$2,790,625
Intensive In-Home*	387	4,553	$1,674,680	$46,485,522	$48,160,202
Multi-Systemic Therapy*	31	746	$1,444,212	$5,018,778	$6,462,990
Medication Management	526	19,078	$140,434	$3,570,997	$3,711,431
Outpatient Therapy	3,010	65,578	$983,199	$56,179,586	$57,162,785
Residential Services	1,439	6,880	$817,735	$258,995,203	$259,812,938
Respite	117	434	$676,287	$0	$676,287

Substance Abuse Services

Substance abuse is a chronic condition much like other chronic diseases, such as diabetes or hypertension. The difference is that uncontrolled diabetes or hypertension usually impacts only the individual and his or her family, whereas an uncontrolled addiction can also cause significant harm to the public, through motor vehicles accidents and lost economic productivity. These societal impacts make it doubly important to help people effectively manage their addiction disorders.

The North Carolina service system is designed to provide a full continuum of treatment services to all people with addictive disorders, due to their limited access to private resources for treatment. Treating addictive disorders effectively requires being ready to initiate treatment and engage individuals in that treatment when they are motivated to seek help. For this reason, all individuals seeking substance abuse services are considered as needing urgent attention (i.e. a first appointment within 48 hours of request) and ongoing treatment (at least four visits within the first six weeks).

The tables below provide summaries of the treatment services provided in SFY 2009 through state and federal funds, where services are based on unit-cost reimbursement. Specialty services provided through grants to service providers and services paid by the individuals served, such as Driving While Intoxicated (DWI) education services and most opioid treatment services, are not included.[4]

[4] Service claims data in the tables here include unit-cost reimbursement services paid through federal block grant funds, Medicaid funds and state appropriations. The data exclude Medicare-funded services, grant-based (non-unit

Table 3: Adult Substance Abuse Treatment Services, SFY 2008-09

Adult SA Service[5]	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Community Support	509	4,463	$1,507,828	$3,675,845	$5,183,673
NOTE: Community support will be eliminated June 30, 2010. The Division estimates that roughly two-thirds of the persons who received Community Support in SFY2009 will need case management or another replacement service.					
Inpatient Hospitalization	164	2,451	$3,324,118	$3,964,732	$7,288,850
Inpatient Physician Services	130	1,562	$128,224	$305,112	$433,336
Medication Management	488	6,087	$491,099	$266,832	$757,931
Methadone Administration	27	3,687	$2,475,674	$5,252,834	$7,728,508
Outpatient Therapy	1,438	18,027	$4,663,990	$3,900,337	$8,564,327
SA Intensive Outpatient*	128	4,522	$7,016,070	$2,751,816	$9,767,886
SA Comprehensive Outpatient*	41	799	$1,146,937	$3,475,796	$4,622,733
SA Halfway House	4	23	$135,082	$0	$135,082
Residential Services	6	5	$0	$60,169	$60,169
Residential Supports	126	3,592	$14,324,702	$0	$14,324,702

Table 4: Adolescent Substance Abuse Treatment Services, SFY 2008-09

Adolescent SA Service[5]	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Community Support	222	808	$244,993	$1,104,583	$1,349,576
NOTE: Community support will be eliminated June 30, 2010. The Division estimates that roughly two-thirds of the persons who received Community Support in SFY2009 will need case management or another replacement service.					
Inpatient Hospitalization	25	54	$15,276	$229,341	$244,617
Outpatient Therapy	358	1,294	$142,810	$464,201	$607,011
Residential Support	12	132	$987,791	$0	$987,791
Residential Services	95	133	$33,348	$2,687,911	$2,721,259

Intellectual/Developmental Disabilities Services and Supports

An intellectual or other developmental disability (I/DD) is a chronic disability due to mental and/or physical impairments that result from mental retardation, cerebral palsy, autism, and other conditions that manifest before the age of 22 or traumatic head injuries that occur at any age.

based) services, and low volume services. Services provided through county funds and private funds are included only if the LME has elected to report them in the Integrated Payment and Reporting System.

[5] Services with an asterisk (*) include consumers with other disability diagnoses listed on the claim.

These conditions usually result in lifelong need for individualized, multi-disciplinary services and supports.

Individuals with I/DD have substantial functional limitations in at least three of the following areas: self-care, language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. Only a small proportion of individuals with I/DD have severe functional impairments in these areas. However the needs of these individuals are typically great.

Services for person with I/DD can range from personal assistance in activities of daily living, home modifications, and assistive technology to accessible transportation, educational supports, and vocational services, depending on their individual needs.

North Carolina has designed its system to serve those who have the highest need for ongoing care and limited access to privately-funded services. The tables below provide summaries of the services and supports for individuals with I/DD that were provided in SFY 2009 through state and federal funds. Most I/DD services are provided through Medicaid funds.[6]

Table 5: Adult Intellectual & Developmental Disability Services and Supports, SFY 2008-09

Adult I/DD Service[7]	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Targeted Case Management	526	10,919	$1,826,839	$43,179,221	$45,006,060
Day Habilitation / Support	306	6,376	$27,087,583	$56,009,043	$83,096,626
Developmental Therapies	414	2,231	$14,687,657	$0	$14,687,657
Guardianship	25	185	$472,188	$0	$472,188
ICF-MR (Community and State)	322	3,860	$0	$449,331,280	$449,331,280
Medication Management	272	1,422	$24,818	$146,786	$171,604
Neuromedical Care (State)*	4	407	$0	$36,369,657	$36,369,657
Other CAP Waiver Services	78	1,983	$0	$3,809,512	$3,809,512
Outpatient Therapy	499	1,668	$40,984	$426,788	$467,772
Personal Care	735	4,474	$11,748,052	$40,822,412	$52,570,464
Residential Services	23	26	$156,940	$504,305	$661,245
Residential Supports	1,259	8,423	$62,060,048	$228,302,054	$290,362,102
Respite	477	4,332	$817,655	$17,283,873	$18,101,528
Supported Employment	315	2,930	$4,263,494	$11,405,949	$15,669,443

[6] Service claims data in the tables here include unit-cost reimbursement services paid through Medicaid funds and state appropriations. The data exclude Medicare-funded services, grant-based (non-unit based) services, and low volume services. Services provided through county funds and private funds are included only if the LME has elected to report them in the Integrated Payment and Reporting System.

[7] Services with an asterisk (*) include consumers with other disability diagnoses listed on the claim.

Table 6: Child Intellectual & Developmental Disability Services and Supports, SFY 2008-09

Child I/DD Service	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Targeted Case Management	459	6,237	$1,552,863	$15,915,007	$17,467,870
Day Habilitation / Support	89	636	$3,337,939	$1,674,084	$5,012,023
Developmental Therapies	278	1,631	$9,007,055	$0	$9,007,055
ICF-MR (Community and State)	45	317	$0	$27,811,676	$27,811,676
Medication Management	171	762	$2,443	$131,412	$133,855
Other CAP Waiver Services	72	1,752	$0	$4,608,324	$4,608,324
Outpatient Therapy	663	2,234	$7,753	$1,315,752	$1,323,505
Personal Care	391	3,175	$2,055,666	$25,641,004	$27,696,670
Residential Services	130	138	$0	$3,899,271	$3,899,271
Residential Supports	336	3,391	$1,682,987	$70,781,684	$72,464,671
Respite	393	3,829	$1,128,138	$11,053,795	$12,181,933
Supported Employment	22	29	$15,228	$15,876	$31,104

Prevention and Early Intervention Services

Mental Health Promotion and Early Intervention

Mental health is fundamental to health and human functioning. In addition to serving people diagnosed with mental illnesses, the Division uses federal and state funds to work with its partners to promote mental health among North Carolinians and to prevent some of the more negative consequences of mental illnesses.

- **Early Childhood and School-Based Behavioral Health:** The Division, in partnership with families, other DHHS agencies, physical and behavioral health care providers, and schools, develops and implements strategic community plans for prevention, early identification, and intervention. This collaboration has resulted in greater access to services for young children with behavioral challenges, a preschool behavior support program, evidenced based parent-child practices, and a kindergarten health assessment.
- **NC Families United - Family Partners in System of Care:** This is a statewide organization of families of children and youth experiencing serious emotional disturbances or mental illnesses and those in recovery. It works in partnership with the Division to recruit, train and support Family Partners who work with each LME's System of Care Coordinator and/or Child and Family Support School Teams Coordinator to provide training from the family's perspective on working in Child and Family Teams and to educate communities about mental health, mental illness and recovery.
- **Powerful Youth:** This statewide organization of youth diagnosed with or in recovery from mental illness organizes trainings and presentations on mental health, mental illness, and recovery. It works to promote youth leadership and engagement in the systems in

which they participate daily (family, school, recreation, and vocation) and to build young people's knowledge of how to take care of their mental health.

- **NAMI Family-to-Family and Family Basics:** The Division supports this program to train families with a child, youth, adult child, or family member who is experiencing serious mental illness on national family support and recovery models in communities statewide. In turn these families become support families for others with similar needs in the community.
- **Eliminating Barriers Initiative:** People with mental illness often are reluctant to seek care due to perceived (stigma) as well as real barriers (lack of insurance, loss of a job, lack of qualified clinical treatment providers). This national program uses public education to reduce the stigma that limits opportunities for people with mental illness to be included fully in community life. The Division participates in the National Anti-Stigma campaign, media outreach teleconferences, and the "What a Difference a Friend Makes" campaign, which targets youth. In addition, the Division hosts a webpage dedicated to eliminating stigma and discrimination of those with mental illness.
- **Co-Location of Primary and Behavioral Health Care:** Co-located offices that include both medical and behavioral health practitioners help to inform primary care providers about mental health issues, while providing earlier services to persons in need. In turn, these integrated practices help behavioral health practitioners become more aware of the physical health needs of persons with mental illnesses.
- **Suicide Prevention**: The Department uses several cross-agency initiatives to reduce the incidence of suicide among North Carolinians. The State's Suicide Prevention Hotline is linked with the round-the-clock Crisis line in each LME and with the national lifeline, 1-800-273-TALK. "Saving Tomorrow Today," the State's youth suicide prevention plan, is a cooperative effort between the Division of Public Health and the Division of MH/DD/SAS. These divisions also work on suicide prevention through the Healthy Carolinians plan and implementation of a federal Garrett Lee Smith grant. In addition, geriatric and adult mental health specialty teams provide training in suicide prevention to long-term care facility staff and caregivers of older adults who are at risk for psychiatric hospitalization. Finally the Division helps to support the Yellow Ribbon program with the National Organization for People of Color against Suicide (NOPCAS) the ACE (Ask, Care, Escort) military suicide prevention program, and gatekeeper training for all who engage with children and youth in schools and communities at large helping identify 'safe and open' support with those who may demonstrate signs and symptoms.
- **Crisis Intervention Teams:** Crisis Intervention Teams (CIT) are police-based, pre-booking programs that help to provide people in mental health crisis the care they need instead of incarceration. CITs give law officers the knowledge and skills that help to:
    - Improve law enforcement attitudes and knowledge about persons with mental illness and community resources for helping them
    - Reduce officer and consumer injuries
    - Increase referrals of persons with mental illness to treatment
    - Reduce arrests of persons with mental illness
    - Reduce costs to the criminal justice system

Through partnerships with law enforcement, mental health professionals, and advocates, the Division has established 18 award-winning CIT programs, which have trained and certified 2,135 CIT law enforcement officers as of January 2010. A total of 149 law enforcement agencies across the state now have CIT-trained officers on staff.

- **Jail Diversion:** Jail Diversion Programs are post-booking programs designed to divert people with mental illness or co-occurring mental illness, substance abuse problems and/or developmental disabilities from the criminal justice system into the treatment, services and supports they need to live successfully in their communities. The Division and its partners have developed jail diversion programs in 18 counties. Jail diversion professionals screen detainees for the presence of a mental illness, work with the court to negotiate the terms of community treatment as an alternative to incarceration, and link consumers to those services. These programs have resulted in an average of 3,174 fewer jail days per year per program, which translates into about 8.7 fewer inmates in jail each year in those areas where jail diversion programs exist. Persons with mental illness who have been diverted from jail to treatment have shown:
    - Higher functioning of standardized tests
    - Lower rates of substance abuse
    - Lower rates of homelessness
    - Higher rates of employment.

Substance Abuse Prevention and Early Intervention

Any comprehensive system of substance abuse care begins with a strong prevention effort, targeting primarily youth and young adults. Excessive drinking during adolescence can cause permanent damage to the development of the portions of the brain that govern reasoning and logic. In addition, youth who begin drinking before the age of fifteen are more likely to become alcohol dependent later in life. According to Substance Abuse and Mental Health Services Administration (SAMHSA), communities can save four to five dollars for every dollar spent on prevention (NC IOM, 2009).

The DMH/DD/SAS uses state and federal funds to support a number of evidence-based prevention programs for information dissemination, education, alternatives to drinking, problem identification and referral, and other community-wide strategies to reduce or prevent substance abuse. In SFY 2008-09 these programs served over 83,000 adults and 125,000 adolescents in the State. In addition, the Division works with other state agencies to conduct ongoing initiatives:

- **Strengthening Families Program:** Through a federal grant, high-risk 6-12 year old children and their parents participate in a 14-week family skills training program to increase resilience and reduce risk factors for substance abuse, depression, violence, and aggression, delinquency and school failure. The curriculum focuses on parent skills, child skills, and family life skills. Research clearly demonstrates this program prevents substance abuse, conduct disorders, depression in children and parents, and improves family relationships.
- **Safe and Drug Free Schools and Communities Program**: This federal entitlement program supports school- and community-based programs to enhance students' resiliency skills and reduce risks for drug use or violence. During the 2008-09 SFY these programs served over 4,500 youth and adults in the State.

- **Preventing Underage Drinking Initiative**: This program is designed to prevent underage and high-risk drinking through community mobilization and partnerships with law enforcement, for programs such as alcohol purchase surveys, sobriety checkpoints, responsible server training, media advocacy, youth empowerment, and policy advocacy. Participating communities have seen declines in early initiation and current use of alcohol by youth, binge drinking, and riding in a car with someone who has been drinking.
- **Synar Program to Reduce Tobacco Sales to Minors:** The Federal Synar Amendment to the Public Health Service Act requires all states to ensure that merchants do not sell tobacco products to youth under age eighteen. Annual inspections of tobacco retail outlets indicate that illegal tobacco sales to minors in North Carolina have fallen from a rate of 50% in 1996 (meaning half of the retailers surveyed sold tobacco products to a minor) to below 15% in SFY 2009.
- **Community Initiatives to Reduce Alcohol-Related Traffic Crashes:** Through a federal grant, the Division is supporting efforts in eighteen high-need communities to reduce alcohol-related traffic crashes and fatalities by building local capacity to identify and address the causes of this problem.
- **Treatment Accountability for Safer Communities (TASC):** The TASC program provides services for individuals involved in the criminal justice system who have substance use problems. In FY08-09, TASC served 19,243 offenders, an increase of 196% over the past 10 years. Services include:
    - Screening and assessment
    - Referral and placement
    - Care planning, coordination and management
    - Reporting to the justice system
- **Driving While Intoxicated (DWI) Services:** This self-sustaining program includes policy, training & oversight of DWI-related treatment and education services across the state. In SFY 2008-09, there were 48,571 people charged with DWI who had a clinical substance abuse assessment. Of those, 28,697 DWI offenders completed the services required to be eligible to have their license reinstated in FY08-09.
- **Drug Education Schools:** The NC Drug Education Schools are a statewide program that gives persons with simple drug offenses an alternative to jail. Instead, offenders receive services through substance abuse providers in cooperation with the District Attorney's office. The goal is for the student to be able to develop a personal plan to eliminate, avoid and/or reduce substance use and its consequences, including recidivism. Of the 1,370 students served in SFY 2008, 82% passed their classes and were eligible to have their legal charges expunged.

Intellectual / Developmental Disabilities Prevention and Early Intervention

Early intervention is critical for helping persons with intellectual and developmental disabilities to live full lives in communities of their choice. Education and monitoring can minimize later problems from medical conditions or behavioral issues that can develop if left unaddressed.

- **Education for Individuals with I/DD and Their Families:** The Division contracts with several organizations in the state to educate and support individuals and families to maximize their physical and mental health, including:

  - Education for individuals with I/DD and their families about services and supports available through the public service system,
  - Information for individuals and families about their rights and responsibilities
  - Community supports to ensure that individuals with I/DD receive regular primary health care, dental services, and other needed care
- **Traumatic Brain Injury Prevention:** Traumatic brain injuries occur as a result of a variety of accidental and intentional activities. The Division works with the Brain Injury Association of NC to educate the public about how to take precautions to prevent brain injuries through actions such as wearing seat belts when in a vehicle and protective helmets when playing sports. In addition the Division works with other agencies to coordinate initiatives such as Project Star and the NC Safe Kids program to educate youth about preventing brain injuries.
- **Screening for Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorders (FASD):** FAS is the leading cause of mental retardation. FASD, a related set of conditions, result in behavior problems in children. Both are completely preventable. The Division, in partnership with university medical centers, primary health care providers and community coalitions, promotes public education about the relationship between alcohol use during pregnancy and these conditions and screening programs for early detection of problems and treatment as needed.

Cross-Disability Services

Crisis Services

Persons dealing with all three disabilities face acute problems periodically. Thus, individual crisis / back-up plans, first responder assignments, and emergency services form the safety net of the service system.

North Carolina has designed its crisis system to serve anyone in the state who experiences an acute need for urgent care. The table below provides a summary of the crisis services that were provided in SFY 2009 through state and federal funds.[8]

Table 7: Crisis Services, SFY 2008-09

Crisis Service	Billing Provider Sites	Persons Served	State Claims Paid	Medicaid Claims Paid	Total Claims Paid
Mobile Crisis	99	9,485	$2,390,959	$2,341,984	$4,732,943
Facility Based Crisis	40	5,762	$7,102,675	$1,740,023	$8,842,698
Detox: Non-Hosp Medical	15	1,454	$2,540,584	$171,122	$2,711,706
Detox: Social Setting	4	1,630	$884,005	$0	$884,005

Note: Some duplication in counts of persons receiving Facility Based Crisis Services may be included.

[8] Service claims data in the tables here include unit-cost reimbursement services paid through Medicaid funds and state appropriations. The data exclude Medicare-funded services, grant-based (non-unit based) services, and low volume services. Services provided through county funds and private funds are included only if the LME has elected to report them in the Integrated Payment and Reporting System.

Co-Occurring Conditions

Many people with mental illness also have a co-occurring addictive disorder or developmental disability. Co-occurring addictive diseases and developmental disabilities are also common. During SFY 2009 the Division provided services to over 27,000 children, adolescents, and adults who had co-occurring conditions.

Co-occurring conditions raise the complexity of individual challenges and societal costs well beyond those associated with each disability in isolation. Co-occurring conditions are associated with a variety of negative outcomes, including high rates of relapse, hospitalization, violence, incarceration, and homelessness. In addition, co-occurring disorders are often chronic and/or episodic and result in declining health, especially when coupled with medical conditions, such as diabetes or liver disease. For these reasons, prevention and treatment services must be designed to address co-occurring conditions.

Co-occurring disorders represent a challenge due to differences in types and severity of impairments contributed by various combinations of disorders and the combined (and not simply additive) needs for treatment resulting from each. In particular, there is a need for more refined diagnostic assessment and development of comprehensive treatment and rehabilitation goals that address both physical and behavioral health issues simultaneously. There is also need for better understanding of how combinations of pharmacological, psychosocial, behavioral and environmental approaches can be used to achieve service goals.

Many of the current services for persons with mental illness or addictive diseases are designed to address the needs of persons with co-occurring conditions. However, historically practitioners have specialized in serving one population alone. The shift to providing integrated care takes time and continued education.

Primary Care Services

People with mental illness, developmental disabilities, and/or addictive disorders are at risk for serious medical problems. Examples include traumatic brain injuries coupled with loss of a limb, addiction introduced by medications for chronic pain, or schizophrenia compounded by diabetes. Despite these issues, people with behavioral health conditions and developmental disabilities often receive inadequate primary care, even though they routinely take medications with serious side effects and often live in unsafe conditions that put their health at risk.

They are prominent among the more than 1.5 million North Carolinians who lack health insurance coverage. According to the NC Institute of Medicine, people without insurance are less likely to receive preventive services or have a regular medical provider, and are more likely to delay seeking necessary care than those with insurance coverage. As a result, they often end up using the emergency department for routine care or entering a hospital with conditions that could have been prevented if treated earlier.

The lack of insurance coupled with co-occurring medical conditions, unsafe living arrangements, and a reliance on medications with serious side effects results in persons with behavioral health conditions and developmental disabilities having much shorter life expectancies than the general population. These trajectories render the traditional "acute care" model of service delivery inadequate to achieving optimal outcomes and functioning for persons suffering from these disabilities. Comprehensive, ongoing services are important not only for persons currently suffering from co-occurring disorders, but also for those at risk for developing co-occurring

illnesses. In addition to the need for attention to co-occurring conditions, people with chronic MH/DD/SA problems all need regular medical exams and dental care.

As shown in the following sections, many of the needs of persons with mental illnesses, intellectual/developmental disabilities, addictive diseases, and co-occurring health conditions are highlighted by the various partners in the North Carolina MH/DD/SA service system.

Local Service System Gaps and Community Needs

Local Management Entity Needs Assessments

All Local Management Entities (LMEs) are required to conduct an annual assessment of the needs in their counties' MH/DD/SA service system as a component of the *DHHS-LME Performance Contract*. The LMEs submitted the results of their most recent needs assessments to the Division in April 2009. The following section provides an overview of key themes and recurring issues faced by all LMEs. An excerpt of each LME's identified needs and priorities is included in Appendix A.

Cross-disability issues

- Affordable and safe housing options
- Employment training and options
- Public and free transportation options
- Lack of awareness among public regarding availability of services and how to access them
- Lack of after hour services and appointments
- Lack of culturally and linguistically appropriate services
- Need to develop and expand to a comprehensive and integrated service network
- Need to develop dual diagnosis services
- Need for expansion and development of crisis services
- Incentives to providers to improve the service growth and delivery
- Expansion of services to remote and rural areas

Mental Health

- Lack of access to and delay in receiving psychiatric services (psychiatric evaluation and assessment)
- Mental health services for juvenile offenders

Substance Abuse

- Expansion of substance abuse services and provider network
- Child and adolescent substance abuse services (including SAIOP, MST, and IIH)

Developmental Disabilities

- Need for increased waiver slots

In addition to the common themes mentioned above, LMEs identified key services for growth in their individual catchment areas. These included crisis services, emergency respite, halfway houses, residential living services, school based services and services for persons with sexualized behaviors.

Consumer and Family Advisory Committees' Recommendations

The State Consumer and Family Advisory Committee (State CFAC) is a 21 member, self-governing and self-directed organization mandated to advise the DHHS and the General Assembly on the planning and management of the State's public MH/DD/SA service system. The State CFAC is comprised of individuals and/or family members of those receiving services for each of the three disabilities who are selected to represent the views of consumers and family members across the state.

The State CFAC conducted its annual survey of Local CFACs in May 2009 to identify service gaps and underserved populations and to recommend improvements regarding the service array. The State CFAC is presenting its recommendations to the General Assembly in a separate document. Those results of the survey are summarized below.

The priorities identified by the State CFAC fall into the following five categories. Below each topic, specific responses from the survey are included, which were edited by the State CFAC for grammar, punctuation, and length, without affecting the original content.

SERVICES

- Service array does not meet the needs of all identified population groups.
- Improve the availability and quality of outpatient mental health and substance abuse services.
- Increase quality programs and slots for all populations to facilitate and maintain independence based on individual needs.
- Quality and timeliness of services is vital and needs to be a priority when establishing LME goals as it enables inclusion for people with disabilities into the fabric of everyday life, creating a more vibrant, inclusive, and interdependent community as a whole.
- Improve Service Quality through workforce development projects and provide State CFAC / Local CFACs with written reports quarterly on progress.
- Equal, consistent MH/DD/SA services.
- Keep Community Support Services in NC. Assign specific accountability within the Division for each of the 2007 Strategic Objectives and require quarterly reporting to State CFAC and Local CFACs on actions and status.
- Improve collaboration between Division and LMEs.
- When appropriate-quality case management.
- CAP-MR/DD waiting list.
- Keep Wright School & Level III & IV Group Homes.
- More concern from state govt. for local issues.
- Privatized Services have not been the answer to improved services for the populations we are supposed to serve. The "REFORM" process has added another layer of overhead. We have one layer with the LMEs and another with the 100's of Service Providers.

GAPS

- Identify minorities and youth.
- Dual diagnosis services.
- Increased transition services from school to work and / or life for all populations.
- Assistance with affordable medications.
- Develop and provide funding for Peer Support Services.
- Increased peer support use. Adolescent services-acute and into adulthood.
- Increased availability of clinical services to Hispanic / Latino consumers.
- Expansion of Jail Diversion Services.
- Recreation and leisure opportunities for people with disabilities which is imperative to good mental health. Overall well-being is undervalued and under funded in our communities.

HOUSING

- More affordable housing needs to be a top priority as housing is grossly inadequate to meet the needs of people with disabilities.
- SA Housing and SA Halfway Housing for women with children.
- Affordable, supported housing (apartments that include apartment clusters, transitional housing, group homes, etc.) with 24 hour supervision that would be handicap accessible, etc.

PROVIDERS

- Quality of Providers.
- Increase availability of psychiatrists and therapists in rural areas.
- Need more psychiatrists in the state.
- Mandate accuracy of provider reporting.
- Insufficient number of providers with sign language proficiency.
- Ongoing, affordable training for providers.

TRANSPORTATION

- Increased affordable and reliable transportation options:
- 24/7 transportation that would be available to help transport individuals to appointments, shopping, work integration (some jobs are after 5 p.m.) particularly needed in rural areas.
- Transportation for people with disabilities is inconsistent, ranging from some service to no service, and is important to the basic needs of Consumers.

North Carolina Institute of Medicine Studies

Over the past several years, the General Assembly has charged the North Carolina Institute of Medicine (NCIOM) with conducting several studies relevant to the needs of the MH/DD/SA service system. The findings of the studies on Substance Abuse and Developmental Disabilities are presented below. Current studies -- on the needs of military families and persons in adult care homes -- are underway as this report is being written. The results will be finalized in SFY 2011.

Task Force on Substance Abuse

In 2007 the NCIOM convened a Task Force on the state's Substance Abuse services. The final report detailing the findings and recommendations of the task force was submitted to the General Assembly in January 2009. The full report can be found on the NCIOM website at http://www.nciom.org/pubs/behavioral.html. The following recommendations of the NCIOM require the participation of the Division of MH/DD/SAS and will impact the public substance abuse service system.

- **Improve substance abuse prevention.** Recommendations included initiating six comprehensive pilot programs and working with partners to develop a plan to prevent alcohol spectrum disorders
- **Reduce underage use of alcohol and tobacco.** Recommendations include developing a plan to further reduce tobacco and alcohol sales to minors, increasing the excise tax on malt beverages (including beer), and supporting efforts to reduce high-risk drinking on college campuses.
- **Coordinate substance abuse care and primary health care.** Recommendations include exploring legal options to allow the exchange of prescription information between health care practitioners, expanding the use of brief interventions in primary care and outpatient settings, supporting the co-location of substance abuse professionals in primary care practices, and mandating that insurers offer the same coverage for treatment of addiction diseases as for other physical illnesses.
- **Develop a recovery-oriented system of care.** Recommendations include supporting six pilot programs to implement local recovery-oriented systems of care.
- **Improve the workforce.** Recommendations include hiring additional substance abuse staff in the Division, training MH/DD/SA professionals about the medical and behavioral health needs of returning veterans and their families, and supporting new residency training rotations for psychiatrists, family physicians, emergency medicine, other physicians likely to enter the addiction field.
- **Expand effective service models.** Recommendations include expanding the Cross Area Service Program Model, staff to work with parents involved with the Work First or Child Protective Services System, the availability of Treatment Accountability for safer Communities (TASC) program services, and treatment services for people involved with drug treatment courts.
- **Enhance data collection systems.** Recommendations include enhancing current data collection systems and working with other agencies to collect data on substance abuse prevention and treatment services.

Task Force on Transitions for Persons with Developmental Disabilities

In 2008 the NCIOM convened a task force to study three types of transitions for persons with developmental disabilities, including: (1) transitions for adolescents leaving high school; (2) transitions for persons who live with aging parents; and (3) transitions for people who move from developmental centers to other settings. The final report detailing the findings and recommendations of the task force was submitted to the General Assembly in May 2009. The full report can be found on the NCIOM website at http://www.nciom.org/pubs/behavioral.html.

The following recommendations of the NCIOM require the participation of the Division of MH/DD/SAS and will impact the public I/DD system of services and supports.

Transitions from School to Postsecondary or Community Settings

- **Improve educational outcomes for children with I/DD.** Recommendations include promoting interagency coordination before a child transitions out of secondary school and determining whether the Assistive Technology needs of students are being met.
- **Expand postsecondary education opportunities for persons with I/DD.** Recommendations include identifying best practices for providing meaningful postsecondary educational opportunities to people with I/DD in an integrated community setting and exploring funding opportunities to support students with I/DD in postsecondary education.
- **Improve transitional services for children in foster care.** Recommendations include ensuring that children in foster care receive an appropriate assessment for I/DD or mental health problems and are linked into the Local Management Entity system, as needed.

Transitions from Large Congregate Settings to Community Settings

- **Review placements in State Developmental Centers and large ICF-MRs.** Recommendations include reviewing admissions prior to placement to determine if the individual with I/DD could be appropriately served in a community-integrated setting.

Transitions for Older Adults with Intellectual and Other Developmental Disabilities (I/DD) and people with I/DD Living with Aging Caregivers

- **Improve pre-crisis planning and outreach to families.** Recommendations include helping families plan for the future, developing long-term emergency housing and supports for people with I/DD when their caretaker becomes ill or dies, and ensuring that older adults with I/DD who are not currently connected to the system have access to services and supports.

Cross-Cutting Issues

- **Develop statewide transition planning.** Recommendations include developing a plan to identify the community services, supports, and funding needed to support successful transitions, hiring developmental disability transitions specialists at the Division and LMEs, and examining the need for flexible funding to support transitions.
- **Improve data systems.** Recommendations include incorporating the needs of people with I/DD into any plans for an electronic health records system and creating an active, computerized system to capture information on the numbers of adults and children who are waiting for services and the types of services needed.
- **Adopt effective funding models.** Recommendations include expanding consumer-directed budgeting, establishing clear accountability standards for case managers, authorizing payments for up to 180 days of case management transition services, and paying the same rates to support individuals in home settings as would be provided in licensed facilities.
- **Improve assessments for residential placements.** Recommendations include adopting a validated and reliable assessment instrument to determine relative intensity of support needs for individuals with I/DD and an assessment process for use in assistive living.

- **Increase crisis services, housing, employment, and primary care.** Recommendations include doubling the availability of regional interdisciplinary crisis teams and crisis respite beds for adults with I/DD, examining the adequacy of and barriers to permanent housing and support services, promoting shared living arrangements, expanding employment opportunities for people with I/DD, and ensuring that Medicaid recipients with I/DD can access medical, dental, therapy, psychological, behavioral, or other services.
- **Improve Workforce.** Recommendations include enhancing training for health professionals in providing coordinated health services for people with I/DD, expanding clinical and residency rotations in settings for people with I/DD, expanding mini-fellowships in developmental medicine, and improving the competencies and skills of developmental social workers.

Stakeholder Group Recommendations

In addition to the LME and CFAC recommendations, the Division requested input from other partners in the state service system. The following summaries provide input from the perspectives of groups that include consumers, family members, advocacy organizations, and MH/DD/SA service provider organizations. More detailed information on each group is provided in Appendix B. The groups were asked to submit their membership's recommendations for pressing needs that the state should address.

Coalition for Persons Disabled by Mental Illness

The Coalition for Persons Disabled by Mental Illness CPDMI) is composed of state-wide, non-profit advocacy, consumer, family and provider organizations who advocate for adequate, quality public services for citizens of North Carolina with mental illness. In response to input on the Division's request, CPDMI submitted the following recommendations:

- **Housing & Supportive Living**
  - *Continue to fund the disability housing programs which began as the "Housing 400" project* through the Housing Finance Agency with an annual appropriation of 10 million dollars with an aim to serve an additional 800 individuals per year.
  - These needs go beyond the $10m for "Housing 400" and require the long-term support of additional service funds of 7 million per year to *begin reducing the number of people with mental illness in adult care home/family care homes*.
- **Need for System Integrity**
  - *Evidence-based, clinically sound services* that include trauma-informed care, centers of excellence, peer support
  - System integrity is predicated on the idea that first the system is consistent in all parts of the state. In order for this to happen there must be a foundation. It is our view that this foundation be comprised of the *six Evidence Based Practices*. Also, we recommend the development of at least *three Centers of Excellence* in the next three years in order to increase the clinical and supervisory capacity. We recommend one of these centers have a *trauma care focus* in order to meet the needs of NC veterans and their families.

- **Supported Employment**
  - In order for North Carolina to continue to be a leader in the successful use of Supported Employment as a model for placing citizens with significant disabilities in competitive employment, there must be a *specific and protected funding stream that is designated wholly for long term support.*
  - Also, North Carolina needs to continue to *look for best practice ways to administer long-term support dollars*.
- **Deaf & Mentally Ill Services**
  - Funding is needed to support *a group home in the eastern part of North Carolina*. There is currently only one group home and it is in the western part of the state. Mentally ill deaf consumers are more isolated from their families due to consolidation of services in one geographic area.
  - There is a continuing *need for interpreters* and funds to pay for interpreter services.
  - Funding is needed for *continuous training* – sign language instruction, prevention materials, staff training and broadband connections for video relay.
  - The program at ECU to *teach social workers to work with the deaf* closed due to lack of enrollees. A program is needed in the central portion of North Carolina to attract and train appropriate clinical staff.
  - There is only one inpatient unit – at Broughton. This has made it very difficult for families of persons who are mentally ill and deaf who do not live in the western part of North Carolina to be part of the recovery process. *Residential services are needed in the other regions of the state*.
- **Medications**
  - *Access to generic [drugs]* as clinically indicated
  - *Money to purchase medications* as needed
  - *Remove barriers to receiving medications*, such as prior authorizations
  - Support for greater *medication compliance*

Substance Abuse Federation

The NC Substance Abuse Federation is a consortium of substance abuse organizations and groups that promote policies to assure quality systems of education, prevention, and the expansion of a continuum of treatment services to effectively meet the needs of the substance abuse population.

Based on the findings of the NC Institute of Medicine's Substance Abuse Task Force (see separate section) the Substance Abuse Federation submitted the following gaps and recommendations as relevant to the present circumstances of the state's MH/DD/SA service system.

- **Comprehensive Prevention Services.** North Carolina communities currently lack state funding for prevention services. These services are designed to prevent or delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive substances among users and identify those who need treatment and help them obtain services earlier in the disease process. The North Carolina Institute of Medicine Task Force presented to

the 2009 General Assembly an identified a need for $1,945,000 in SFY 2010 and $3,722,000 to develop and implement these services statewide.

- **Comprehensive System of Specialized Substance Abuse Services Delivered as Cross Area Service Programs (CASPs) for Adolescents and Adults.** North Carolina citizens (children and adults) needing treatment services should have access to a complete array of services organized around a recovery-oriented system of care. These must include but are not limited to outreach, evidence-based treatment models, access to medications and health care, housing, vocational/education and aftercare services in their home communities. The plan should utilize the American Society of Addiction Medicine levels of care.
- **Criminal Justice Service Needs.** Drug Treatment Courts - The IOM identified the need for eight new drug treatment courts. In addition, they indicated the need for $1,140,000 for treatment services for adult drug treatment court participants. In addition, they noted that that - $1,500,000 in recurring funds to the North Carolina Department of Corrections, Division of Alcoholism and Chemical Dependency Program to expand the availability of state substance abuse services to adults within the prison system.
- **Infrastructure gaps** that decease our ability to deliver the most effective services to people in need statewide
- **Electronic Medical Records and Billing Systems.** In order to decrease administrative costs and improve the quality of services and ensure that in the future substance abuse prevention and treatment service providers can meet the requirements to maintain federal funding, providers must develop electronic medical record and billing systems capacity. Unfortunately, the current underfunded system does not support a public providers ability to invent in these quality-enhancing and cost saving tools. Current estimates are that 15% of a clinician's time can be reallocated to client service following implementation of electronic record keeping. Linking these records to electronic billing can further decrease the cost of administrative time.
- **Workforce**. Many communities are struggling with a lack of both trained substance abuse prevention and treatment professionals and the health care professionals that are required to offer the comprehensive services detailed above. Programs should be developed using existing workforce development strategies to address geographical gaps that current exist and are noted in Appendix E of the NCIOM Task Force on Substance Abuse Services. In addition, to ensure the development of the aforementioned comprehensive prevention and treatment services their needs to be adequate staff with knowledge about substance abuse at both the state and local government level. Recommendations for these positions are also included in the NCIOM report.

Developmental Disabilities Consortium

The Developmental Disabilities Consortium includes representatives of individuals with intellectual and developmental disabilities (I/DD), family members, and I/DD service agencies and advocacy organizations. Members come together to advocate for the needs of persons with I/DD.

The Developmental Disabilities Consortium submitted the following list of identified gaps and recommendations, based on the findings of the NC Institute of Medicine Task Force on Transitions (see later section), the DD Summit sponsored by the North Carolina Council on Developmental Disabilities, and other initiatives in which Consortium members were involved.

Across the lifespan of individuals with Intellectual and Developmental Disabilities (I/DD) we see a need for:

- State support of Early Intervention services, inclusive of education to the family;
- Crisis services for children, and a robust crisis system for all individuals with I/DD;
- Opportunities for making contributions to the community, through post secondary education, employment, or other activities which contribute and also produce valued outcomes for people with I/DD;
- Community living services to be designed in a way that achieve valued outcomes that support people to live as independently as they can by ensuring that resources are available to individuals to secure and maintain affordable, accessible homes in the community, along with the services and supports necessary to remain there.
- Supports so that individuals and their families can "age in place", to prevent nursing home and "rest home" admissions of people with I/DD; such supports can include: securing hospice care when needed; and connecting with a "medical home" in their local community.

To ensure the best outcomes in the above areas we recommend:

- Reinstating a **comprehensive, statewide waiting list** that is transparent and based on published criteria; this will improve the ability to plan at all levels.
- **Funding Model** - Develop a funding allocation formula that takes into account population, inflationary increases and the long-term nature of I/DD services and supports. Establish an individual funding allocation model that accounts for all funds; corresponds to the intensity and complexity of an individual's needs; and allows for multiple funding tiers. Give individuals and families the support and tools necessary to control, within CMS guidelines, the use of an individual resource allocation or individual budget.
- Ensure availability and access, statewide, to **specialized medical services**, including: behavioral; primary health; dental services; assistive technology; special vision and hearing supports; and health/wellness supports.
- Ensure a **viable Direct Support Workforce** - Establish statewide, competency- and values-based, portable training and certification requirements for direct support workers, front-line supervisors, and case managers. Develop a state level certification and career path for direct support workers, front-line supervisors, and case managers, based on the demonstration of these competencies. Provide financial support to providers to cover the costs of staff training; the payment of a living wage; and incentives for staff who develop

specialized skills. Ensure that funds allocated for wages pass through to direct support workers.

- Actively recruit and hire **state-level I/DD leadership** with a proven track record (in a state I/DD system) of effectively implementing those practices and policies that both (a.) result in outcomes valued by families and people with I/DD, and (b.) achieve accountability to funders.
- Develop, statewide and within each LME's senior management structure, a **dedicated position for an I/DD specialist** who is knowledgeable about core I/DD concepts and values; program access and eligibility; funding; and the provider network.
- Promote inter-agency collaboration between the Department of Transportation and the Department of Health and Human Services to improve **access to transportation** across the state for people with I/DD.

State Collaborative for Children and Families

The North Carolina State Collaborative for Children and Families, through a System of Care framework, provides a forum for collaboration, advocacy and action among families, public and private child and family serving agencies and community partners, working as an equal team, to improve outcomes for all children, youth and families.

The primary gap identified by the State Collaborative is a lack of funding to truly incorporate family and youth participation in planning and delivery of MH/DD/SA services. The need includes funds to pay parents and youth for activities, such as acting as representatives on policy and planning committees, presenting at conferences, and participating in trainings for service providers, consumers and family members.

Summary and Recommendations

Primary Themes Identified by System Partners

The system gaps and needs identified by the LMEs, NC Institute of Medicine task forces, and other MH/DD/SA service system partners can be grouped into six main themes:

Long Term Supports for Independence and Recovery

- Safe and affordable housing
- Employment Opportunities and Supports
- Emergency respite
- Timely access to affordable medications
- Primary healthcare
- Transportation
- Post-secondary education opportunities
- Recreation opportunities

Quality and Accountability

- Consistent, high quality assessments and services

- Evidence-based practices
- Efficient sharing of information through electronic health records
- Tracking of persons waiting for services

Workforce Development

- Consistent provider trainings
- Residency rotations in SA and DD
- Training in specialty needs, such as integrated care, military families, deaf services and cultural competence, and ESL populations

Expansion of Services

- Education and outreach
- Peer specialists
- After-hours services
- Substance abuse prevention and treatment
- Child & adolescent services (SA, IIH, MST)
- Services in rural areas
- Psychiatric services and telepsychiatry
- Community inpatient psychiatric services
- Dual disability services
- CAP-MR/DD waiver services
- Jail diversion and MH services for persons in justice system

Services for Vulnerable Populations

- Deaf persons
- Persons in transition (to adulthood, from institutional care, to elder care
- High-risk youth (e.g. juvenile offenders, youth with sexualized behaviors)
- Persons with or at risk for chronic illnesses

Leadership and System Management

- Disability-specific specialists at DMH/DD/SAS and LMEs
- Improved State-LME collaboration
- Inter-agency coordination
- Increased Division staffing
- Effective funding policies (case rates, fewer prior authorization requirements, consumer-directed budgets)

Priorities of the Department of Health and Human Services

The Department has begun addressing a number of these areas identified by consumers, LMEs and other stakeholders in recent years. Specifically, creation of a stable, high quality provider system, comprehensive crisis services, and housing and employment opportunities for

individuals with MH/DD/SA disorders have been the focus of Division activities, since their inclusion as goals of the *State Strategic Plan: 2007-2010*. Since this plan's inception, the Division has:

- Implemented standardized processes and tools for endorsing and monitoring providers and ensuring providers' use of a person-centered approach to planning services
- Supported adoption of evidence-based practices through the Practice Improvement Collaborative
- Used appropriations from the General Assembly to enhance local crisis service systems, including community inpatient psychiatric services, mobile crisis services, facility-based crisis and detoxification programs, walk-in clinics and telepsychiatry, START teams and crisis respite beds for persons with I/DD, and acute crisis services in the State Alcohol and Drug Abuse Treatment Centers
- Trained law enforcement officers to become community intervention teams and increased jail diversion programs
- Submitted a request to the federal Centers for Medicare and Medicaid Services to provide peer specialist services and targeted case management
- Increased local efforts to develop affordable housing opportunities
- Increased coordination of services with primary care providers
- Planned development of electronic health records and systems to track persons waiting for services
- Developed a workforce development plan

The current priorities of the Division are to improve the quality and stability of the service system, while maximizing use of existing resources and protecting critical core services. Two new initiatives are underway to address these issues. They are also expected to continue moving the system forward in the areas identified in this report by the LMEs, CFACs, and other stakeholders.

Expansion of Medicaid Waivers 1915(b) and (c)

Medicaid waivers allow states to capitate Medicaid funding and control services at the local level. Expansion of the waiver program currently in place in Piedmont Behavioral Health's catchment area to other LMEs will give these local "prepaid insurance health plans" (PIHPs) both increased flexibility in managing services and increased accountability through assumed risk. The DHHS has applied to the Centers for Medicare and Medicaid Services to expand Piedmont's 1915(b)(c) waiver statewide and plans to select one or two LMEs to begin operating as PIHPs in January 2011.

The goals of this initiative are to:

- More effectively use Medicaid and state funds, while predicting and controlling costs
- Improve the quality of services through financial incentives for use of best practices
- Create economies of scale by influencing the number and size of LMEs
- Improve the use of data for managing services, coordinating care, and improving outcomes for consumers

Critical Access Behavioral Health Agencies

The DHHS is currently designing requirements for critical access behavioral health agencies (CABHAs). These private agencies will provide core services and a continuum of specialty services for a chosen population with oversight by experienced professional staff. Each CABHA is required to have a medical director, clinical director and training / quality management director on staff to ensure adherence to evidence-based practices and quality standards of care. In addition, they will be the only agencies permitted to provide services by non-licensed professionals and consumer peers. The goals of this initiative are to:

- Support quality services through adherence to evidence-based practices and good clinical training, supervision and oversight
- Improve first responder services for consumers in crisis
- Encourage movement of consumers toward recovery through provision of a continuum of care
- Provide employment opportunities for consumers in recovery to support other consumers
- Increase provider accountability and ongoing quality improvement
- Support progress toward a Medicaid waiver environment by creating more comprehensive service providers

Other Initiatives

The CABHA and Medicaid waiver initiatives are major undertakings that will move the public MH/DD/SA service system toward greater stability, accountability, and cost effectiveness. DHHS is engaging significant staff resources to ensure the success of these programs. At the same time, addressing the gaps identified by system stakeholders requires continuation of other initiatives that are already in progress. These priorities include:

- Continuing expansion of crisis and core services across the state
- Increasing community psychiatric inpatient capacity and use of telemedicine
- Continuing the work of the Practice Improvement Collaborative to identify best practices
- Increasing opportunities for consumer and family ownership, through consumer-directed budgets and peer services
- Expanding integrated primary health care and behavioral health care programs
- Building recovery-oriented systems of care for substance abuse
- Expanding availability of cross-area service programs for regional delivery of substance abuse services
- Implementing a Medicaid waiver for services to persons with traumatic brain injuries
- Adopting the Supports Intensity Scale to manage resource allocations for person with I/DD
- Implementing a wait list for I/DD services, as legislated in 2009
- Improving consistency in local provider oversight
- Continuing IT enhancements and integration of data systems
- Improving use of data for forecasting, planning and management
- Exploring ways to address workforce issues

Conclusion

Strategic planning for the MH/DD/SA service system requires DHHS to recognize the current realities of the nation, the state, and the public system as well as the gaps and priorities identified by system stakeholders. The need for more stability, better quality, and strategic use of existing resources must be the paramount concerns that drive policy direction for the immediate future. The Division and Department leadership are committed to using the initiatives described above to address these concerns.

Appendices

A separate document entitled *MH/DD/SAS Gap Analysis Report Appendices* includes:

- **Appendix A: LME Needs Assessment Summaries**
- **Appendix B: Stakeholder Group Descriptions and Membership**